Congressional Research Service
Informing the legislative debate since 1914

Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)

Bernadette Fernandez
Specialist in Health Care Financing

March 12, 2014

Congressional Research Service
7-5700
www.crs.gov
R41137

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

New federal tax credits, authorized under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), first became available in 2014 to help certain individuals pay for health insurance. The tax credits apply toward premiums for private health plans offered through "exchanges" (also referred to as health insurance marketplaces). ACA also establishes subsidies to reduce cost-sharing expenses.

Exchanges have been established in every state, either by the state itself or by the Secretary of Health and Human Services (HHS), as required under ACA. Exchanges are not insurers, but provide eligible individuals and small businesses with access to private health insurance plans. Generally, the plans offered through the exchanges provide a comprehensive set of health services and meet all ACA market reforms, as applicable.

The new premium credits established under ACA are advanceable and refundable, meaning taxfilers need not wait until the end of the tax year in order to benefit from the credit, and may claim the full credit amount even if they have little or no federal income tax liability. Premium tax credits are generally available to individuals who enroll in an exchange plan; are part of a tax-filing unit; have household income between specified amounts; are not eligible for other forms of comprehensive health coverage; and are U.S. citizens or lawfully present residents. This report provides examples of hypothetical individuals and families who qualify for the premium credits; the examples use actual 2014 premium and tax credit amounts.

The amounts received in premium credits are based on federal income tax returns. These amounts are reconciled in the next year and can result in overpayment of premium credits if income increases, which must be repaid to the federal government. ACA limits the amount of required repayments for lower-income enrollees.

In addition to premium credits, ACA authorizes new cost-sharing subsidies. Certain premium credit recipients will also be eligible for reductions in their annual cost-sharing limits. Moreover, certain low-income individuals will receive additional subsidies in the form of reduced cost-sharing requirements (e.g., lower deductible).

Contents

Figures

Tables

Contacts

New federal tax credits were authorized in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), to help certain individuals pay for health insurance coverage, beginning in 2014.[1] The tax credits apply toward premiums for private health plans offered through "exchanges" (also referred to as health insurance marketplaces). ACA also establishes subsidies to reduce cost-sharing expenses.

This report describes the eligibility criteria applicable to the premium tax credits and cost-sharing subsidies, and the calculation method for the credit and subsidy amounts. It also highlights selected issues addressed in the final regulation on premium credits.

Background

ACA requires health insurance exchanges to be established in every state by January 1, 2014, either by the state itself or by the Secretary of Health and Human Services (HHS). The ACA exchanges are not insurance companies; rather, they will coordinate the offer of private health plans to qualified individuals[2] and small businesses.[3] Generally, exchange plans provide a comprehensive set of health services and meet all ACA market reforms, as applicable.[4] In addition, most exchange plans comply with a requirement that measures how much a given plan will pay for a group of individuals (who vary in terms of medical use and expenses); that measure is referred to as actuarial value (AV).[5] Most exchanges plans meet a specific AV; each AV is designated by a precious metal: bronze (actuarial value of 60%), silver (70%), gold (80%), and platinum (90%). For AVs, the higher the percentage, the lower the cost-sharing, *on average*.[6]

Given that ACA specifically requires exchanges to offer insurance options to individuals and small businesses, exchanges are structured to assist these two different types of "customers." Consequently, there is an exchange to serve individuals and families, and another to serve small businesses ("SHOP exchanges"), within each state. However, ACA gives states the option to merge both exchanges and operate it under one structure.

Certain enrollees in the *individual* exchanges are eligible for premium assistance in the form of federal tax credits.[7] Such credits are not provided through the SHOP exchanges. The premium

[1] §1401 of ACA; new §36B of the Internal Revenue Code of 1986 (IRC).

[2] Enrollment in an exchange plan is voluntary; see §1312(d)(3) of ACA. This also applies to Members of Congress and their personal staff who may only be offered coverage, by the federal government, that is created under the ACA or offered through an exchange, per ACA§1312(d)(3)(D). While the federal government may only make certain plans available to applicable Members and staff, such individuals may enroll in any plan that is available to them. For a comprehensive discussion about these issues, see CRS Report R43194, *Health Benefits for Members of Congress and Certain Congressional Staff*.

[3] Before 2016, states will have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, large groups may participate in exchanges, at state option.

[4] See CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

[5] Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. AV is *not* a measure of premiums or the benefits package. Two plans with the same AV may have different premiums and different sets of covered benefits.

[6] Since actuarial value is calculated based on a population, this measure indicates plan generosity for a group. It does *not* indicate the share of medical expenses that the plan will pay for each individual enrolled in a plan. The utility of AV is that it facilitates comparisons across plans, so that an individual/family may use this plan characteristic (along with other factors) to decide on the most appropriate plan given health care needs and disposable income.

[7] For tax years beginning after December 31, 2013, 31 U.S.C. 1324 appropriates necessary amounts to the Treasury (continued...)

credit is an advanceable, refundable tax credit, meaning taxfilers need not wait until the end of the tax year in order to benefit from the credit, and may claim the full credit amount even if they have little or no federal income tax liability. Receiving the credits as advanced payments means that monthly insurance premiums will be automatically reduced by the credit amount. Therefore, the direct cost of insurance to an individual/family will be lower than the "advertised" cost for a given exchange plan.[8]

The Treasury Department promulgated final regulation on the premium credits on May 23, 2012.[9] The final regulation confirmed certain eligibility and other requirements, as specified in statute; such requirements are discussed in applicable sections of this report. In addition, the Internal Revenue Service (IRS) has issued guidance and other documentation (such as Q&As) relevant to premium credits.[10]

Premium Credit Eligibility

ACA specifies that premium credits will be available to "applicable taxpayers" in a "coverage month" beginning in 2014.[11]

An *applicable taxpayer* is an individual who

- is part of a tax-filing unit;
- is enrolled in a plan through an individual exchange; and
- has household income at or above 100% of the federal poverty level (FPL), but not more than 400% FPL.[12]

A *coverage month* refers to a month in which the applicable taxpayer paid for coverage offered through an exchange, not including any month in which the taxpayer was *eligible* for "minimum essential coverage" with exceptions.

These eligibility criteria are discussed in greater detail below.[13]

(...continued)

Secretary for disbursements due under §36B of the IRC. This permanent appropriation means that the premium credits do not require annual appropriations.

[8] The formula for calculating the premium credit amount is such that it is possible for a higher-income person who is technically eligible for a credit to end up receiving no credit to offset the cost of buying insurance. For additional information about this issue, see the discussion under the "Required Premium Contributions and Premium Credit Calculations" section of this report.

[9] 77 *Federal Register* 30377, May 23, 2012.

[10] See the IRS's "Affordable Care Act (ACA) Tax Provisions" webpage for links to such documents, http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions-Home.

[11] §1401(a) of ACA; new §36B(c)(1) of the IRC.

[12] The guidelines that designate the federal poverty level are used in a variety of federal programs for eligiblity purposes. The poverty guidelines vary by family size, and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. Office of the Assistant Secretary for Planning and Evaluation, "Frequently Asked Questions Related to the Poverty Guidelines and Poverty," http://aspe.hhs.gov/Poverty/faq.cfm#programs.

[13] Consumers Union's Tax Credit Brochures are available to help taxfilers determine their eligibility for premium tax credits. See "Cut the Cost of Health Insurance," http://www.consumersunion.org/tax_credit_brochure.

Part of a Tax-Filing Unit

Given that the premium assistance is provided in the form of tax credits, they are administered through the tax system (although advance payments go directly to insurers).[14] The credits can only be obtained by qualifying individuals who file federal tax returns.

Married couples are required to file joint tax returns to claim the credit.[15] The final regulation includes special rules relating to the calculation and allocation of credit amounts due to changes in filing status during a given tax year (e.g., taxpayers who marry or divorce). The final regulation acknowledges that certain circumstances may make filing jointly a challenge (e.g., domestic abuse, abandonment, etc.); it states that the IRS will propose additional rules to address these kinds of circumstances.

Enrolled in an Individual Exchange

Premium credits are available only to individuals and families enrolled in a plan offered through an individual exchange;[16] premium credits are *not* available through the small business ("SHOP") exchanges. Individuals may enroll in a plan through their state's exchange if they are (1) residing in a state in which an exchange was established; (2) not incarcerated, except individuals in custody pending the disposition of charges; and (3) "lawfully present" residents.[17]

Only lawful residents are allowed to obtain exchange coverage. Undocumented individuals are prohibited from purchasing coverage through an exchange, even if they could pay the entire premium without a subsidy.[18] Because ACA prohibits undocumented individuals from obtaining exchange coverage, they are *not* eligible for premium credits.

The final regulation clarifies the potential credit eligibility for family members of individuals who themselves are *not* eligible to enroll in an exchange due to incarceration or legal status. For example, while the final regulation restates ACA's prohibition on incarcerated individuals enrolling in exchange plans, the rule confirms that family members (of incarcerated individuals) who enroll in exchange plans may receive premium credits, as long as the family members meet all eligibility criteria.[19]

---

[14] §1412(a)(3) of ACA.

[15] On June 26, 2013, in United States v. Windsor, the U.S. Supreme Court struck down Section 3 of the Defense of Marriage Act (DOMA), finding that it violated the equal protection guarantees of the Fifth Amendment. Section 3 had required that, for purposes of federal enactments, marriage be defined as the union of one man and one woman. In light of this ruling, HHS issued guidance which stated that same-sex spouses will be treated just like opposite-sex spouses for premium credit eligibility purposes. See Centers for Medicare & Medicaid Services, "Guidance on Internal Revenue Ruling 2013-17 and Eligibility for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions," Sept. 27, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs-2013-17.pdf.

[16] HHS issued guidance about the potential availability of premium credits for individuals who did not receive timely eligiblity determinations or were not enrolled in a timely manner due to technical issues related to exchanges. For additional information about the availability of retroactive premium credits, see "CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances," February 27, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf.

[17] §1401(a) of ACA; new §36B of the IRC.

[18] §1312(f)(3) of ACA.

[19] See discussion under "Individuals not lawfully present or incarcerated," 77 *Federal Register* 30377, May 23, 2012.

Household Income Is 100%-400% of Federal Poverty Level

To be eligible for premium credits, individuals must have "household income" within statutorily defined guidelines based on the federal poverty level (FPL).[20] For purposes of premium credit eligibility, household income is measured according to the definition for "modified adjusted gross income" (MAGI).[21] An individual whose MAGI is at or above 100% FPL up to and including 400% FPL may be eligible to receive premium credits.[22]

Table 1 displays the income levels at 400% FPL, the amount *beyond* which individuals and families would *not* be eligible for premium credits in 2014 (using 2013 HHS poverty guidelines).[23]

Table 1. Income Levels at 400% FPL Applicable to 2014 Premium Credit Eligibility

Based on 2013 HHS Poverty Guidelines

Number of Persons in Family	48 Contiguous States and DC	Alaska	Hawaii
1	$45,960	$57,400	$52,920
2	$62,040	$77,520	$71,400
3	$78,120	$97,640	$89,880
4	$94,200	$117,760	$108,360
5	$110,280	$137,880	$126,840
6	$126,360	$158,000	$145,320
7	$142,440	$178,120	$163,800
8	$158,520	$198,240	$182,280

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

[20] The poverty guidelines are updated annually, at the beginning of the year. However, premium credit calculations are based on the prior year's guildelines, in order to provide individuals with timely information as they compare and enroll in exchange plans during the open enrollment period (which occurs prior to the begining of the plan year). For the poverty guidelines used to calculate the credit amounts for 2014, see "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

[21] In §2002(a) and §1401(a) of ACA, household income is defined to be MAGI, in compliance with the Internal Revenue Code (IRC). Under the IRC, gross income is total income minus certain exclusions (e.g., public assistance payments, employer contributions to health insurance payments). From gross income, adjusted gross income (AGI) is calculated to reflect a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments. MAGI is defined as AGI plus certain foreign earned income and tax-exempt interest. However, for premium credit eligibility purposes, the definition of MAGI will also include nontaxable Social Security benefits (as amended by P.L. 112-56). For additional discussion about the use of MAGI with respect to ACA premium credits, see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*.

[22] There are two exceptions to the lower bound income threshold at 100% FPL. One exception relates to the state option under ACA to expand Medicaid for individuals with income up to 133% FPL (with a 5% income disregard). If a state chooses to undertake the ACA Medicaid expansion (or has already expanded Medicaid above 100% FPL), eligibility for premium credits would begin above the income level where Medicaid eligibility ends in such a state. (Note that in states that do not expand Medicaid to at least 100% FPL, some low-income state residents are *in*eligible for both premium credits and Medicaid.) The other exception is for lawfully present aliens with income below 100% FPL, who are *not* eligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of premium credit eligibility.

[23] See Internal Revenue Service, "Questions and Answers on the Premium Tax Credit," Q&A #6, http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit.

Notes: For 2014, the income levels used to calculate premium credit eligibility and amounts are based on 2013 HHS poverty guidelines. The poverty guidelines are updated annually for inflation. "DC" is the District of Columbia.

Not Eligible for "Minimum Essential Coverage"

To receive a premium credit, an individual may *not* be *eligible* for "minimum essential coverage," with exceptions (described below). ACA broadly defines minimum essential coverage to include Medicare Part A; Medicare Advantage; Medicaid (with exceptions); the State Children's Health Insurance Program (CHIP); Tricare; Tricare for Life, a health care program administered by the Department of Veterans Affairs (VA);[24] the Peace Corps program; any government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP); any plan offered in the individual health insurance market; any employer-sponsored plan (including group plans regulated by a foreign government); any grandfathered health plan;[25] any qualified health plan offered inside or outside of exchanges; and any other coverage (such as a state high risk pool) recognized by the HHS Secretary.[26]

Exceptions to Minimum Essential Coverage Eligibility

ACA provides certain exceptions regarding eligibility for minimum essential coverage and receipt of premium credits:

- An individual who is only eligible to obtain coverage through the individual (nongroup) health insurance market[27] may be eligible to receive a premium credit.
- An individual eligible for an employer-sponsored plan may still be eligible for premium credits if the employer's coverage is either (1) not affordable; that is, the employee's premium contribution toward the employer's self-only plan exceeds 9.5% of household income;[28] or (2) does not provide minimum value;

[24] The IRS final regulation on premium credits stated that for premium credit eligibility purposes, a person would be considered "eligible" for a VA health program only if that person is actually enrolled in such a program. Therefore, individuals who could enroll in such programs, but choose not to enroll, may be eligible for premium credits, providing they meet all other eligibility criteria. See discussion under "Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, U.S.C.," 77 *Federal Register* 30377, May 23, 2012.

[25] A grandfathered health plan is a group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled since the date of enactment of ACA. For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*.

[26] The IRS final regulation on premium credits addresses various circumstances when individuals transition between exchange coverage and public coverage, such as Medicaid. For example, the regulation discusses the process and time period applicable to an individual who becomes eligible for "government-sponsored coverage," and therefore becomes ineligible for premium credits. See discussion under "Government-Sponsored Coverage" and "Determination of Medicaid or Children's Health Insurance Program (CHIP)," 77 Federal Register 30377, May 23, 2012.

[27] The private health insurance market will continue to exist outside of the ACA exchanges. Moreover, almost all types of exchange plans are allowed to be offered in the market outside of exchanges. For additional information about health plans that are allowed to be offered inside and/or outside of exchanges, see CRS Report R43233, *Private Health Plans Under the ACA: In Brief*.

[28] The IRS final regulation on premium credits confirms that an employee safe harbor will be provided to an individual who is determined to be eligible for premium credits, but later determined that the worker was eligible for affordable employer coverage. Moreover, the employer would not be subject to a penalty because a full-time employee receives a premium credit under the safe harbor. For a discussion of ACA's employer requirements, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*.

that is, the plan's payments cover less than 60% of total allowed costs on average.[29]

- An individual who is eligible for limited benefits under Medicaid may still be eligible for premium credits (see "Medicaid" section below for additional information).

Employer Contribution Toward Coverage in SHOP Exchanges

Certain small employers (and in later years, large employers at state option) may offer and contribute toward coverage through SHOP exchanges. If an individual is enrolled in an exchange through an employer who contributed toward that coverage, the individual will *not* be eligible for premium credits.[30]

Medicaid

ACA's Medicaid expansion provisions have the potential for affecting eligibility for premium credits if certain low to middle income individuals and families seek health insurance through the exchanges. Under ACA, states have the *option* to expand Medicaid eligibility to include all non-elderly, non-pregnant individuals (i.e., childless adults and certain parents, except for those ineligible based on certain noncitizenship status) with income up to 133% FPL.[31] (ACA does not change noncitizens' eligibility for Medicaid.[32]) States that choose to implement the ACA Medicaid expansion will receive substantial federal subsidies.[33] If a person who applied for premium credits in an exchange is determined to be eligible for Medicaid, the exchange must have them enrolled in Medicaid.[34] Therefore, any state that expands Medicaid eligibility to include persons with income at or above 100% FPL (or any state that currently includes such individuals) would make such individuals ineligible for premium credits. Premium credit eligibility in such a state begins at the income level where Medicaid eligibility ends.

In general, a person may be eligible for only one subsidized health coverage program at a time. However, exceptions are made for individuals who are eligible only for limited benefits under Medicaid; limited benefits include the pregnancy-related benefits package, treatment of emergency medical conditions only, and possibly other limited benefits. Individuals who have access to only these specific limited benefits under Medicaid may qualify for premium credits if such individuals enroll in exchanges.[35]

---

[29] §1401(a) of ACA; new §36B(c)(2)(C) of the IRC.

[30] §1401(a) of ACA; new §36B(c)(2)(A)(ii) of the IRC.

[31] ACA specifies that an income disregard in the amount of 5% FPL will be used to determine Medicaid eligibility based on modified adjusted gross income; thus, the effective minimum income eligibility threshold for such individuals in this new Medicaid eligibility group will be 138% FPL.

[32] As under law prior to ACA, certain lawfully present aliens are eligible for full Medicaid benefits (e.g., refugees, asylees, and some legal permanent residents (LPRs) who have been here at least five years), while others are not (e.g., certain LPRs who have been here less than five years).

[33] See CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

[34] §§1311(d)(4) and 1413(a) of ACA. Nonetheless, nothing in ACA prohibits a Medicaid-eligible individual from enrolling in an exchange on his/her own. However, that individual will be responsible for the entire cost of exchange coverage, which will likely be prohibitive for a low-income individual.

[35] See Health Reform GPS, "When Does Medicaid Coverage Amount to Minimum Essential Coverage Under the Affordable Care Act? An Update on the Treasury/IRS Rules Defining Minimum Essential Coverage," February 11, 2014, http://www.healthreformgps.org/resources/when-does-medicaid-coverage-amount-to-minimum-essential-
(continued...)

Required Premium Contributions and Premium Credit Calculations

The amount of the premium tax credit varies from person to person; the credit is based on the household income of the taxfiler (and dependents), the premium for the exchange plan in which the taxfiler (and dependents) is (are) enrolled, and other factors. In certain instances, the credit amount may cover the entire premium and the taxfiler pays nothing toward the premium. In other instances, the taxfiler may pay part (or all)[36] of the premium.

The calculation of the credit amount is based on a comparison of two amounts that result from two different scenarios. The first scenario (and amount) is straightforward: the premium for the exchange plan in which the person/family enrolls. The second scenario is more complicated: it involves a formula that considers the premium for a standard plan in the local area in which the person/family resides, and an amount that the person/family may be required to contribute toward the premium. Based on a comparison of the amounts resulting from each scenario, the premium credit will be the lesser amount. The following text box, "Calculation of the Premium Credit Amount," discusses these two scenarios in more detail.

Calculation of the Premium Credit Amount

The premium credit amount will be the *lesser* amount resulting from either:

Scenario A: The cost of the exchange plan that the taxfiler (and dependents) is (are) enrolled in;

Or

Scenario B: The excess, if any, resulting from the following formula:

The age-adjusted premium for the second-lowest cost silver plan in the taxfiler's area ("reference plan"),

Minus

The product of the taxfiler's household income and the "applicable percentage" (explained in greater detail below), based on the taxfiler's household income relative to the federal poverty level.

Enrollee Premium Contribution

The enrollee premium contribution will be based on the lesser amount calculated above.

Scenario A: If the premium credit is based on the amount calculated under Scenario A, then the taxfiler (and dependents) pay(s) nothing toward the premium for exchange coverage.

Scenario B: If the premium credit is based on the amount calculated under Scenario B, then the taxfiler (and dependents) pay(s) some amount toward the premium for exchange coverage.

(...continued)

coverage-under-the-affordable-care-act-an-update-on-the-treasuryirs-rules-defining-minimum-essential-coverage/.

[36] The formula for calculating the premium credit amount is such that it is possible that the result may be a credit of zero dollars, meaning the person/family pays the entire exchange premium. See the text box "Calculation of the Premium Credit Amount" for additional information.

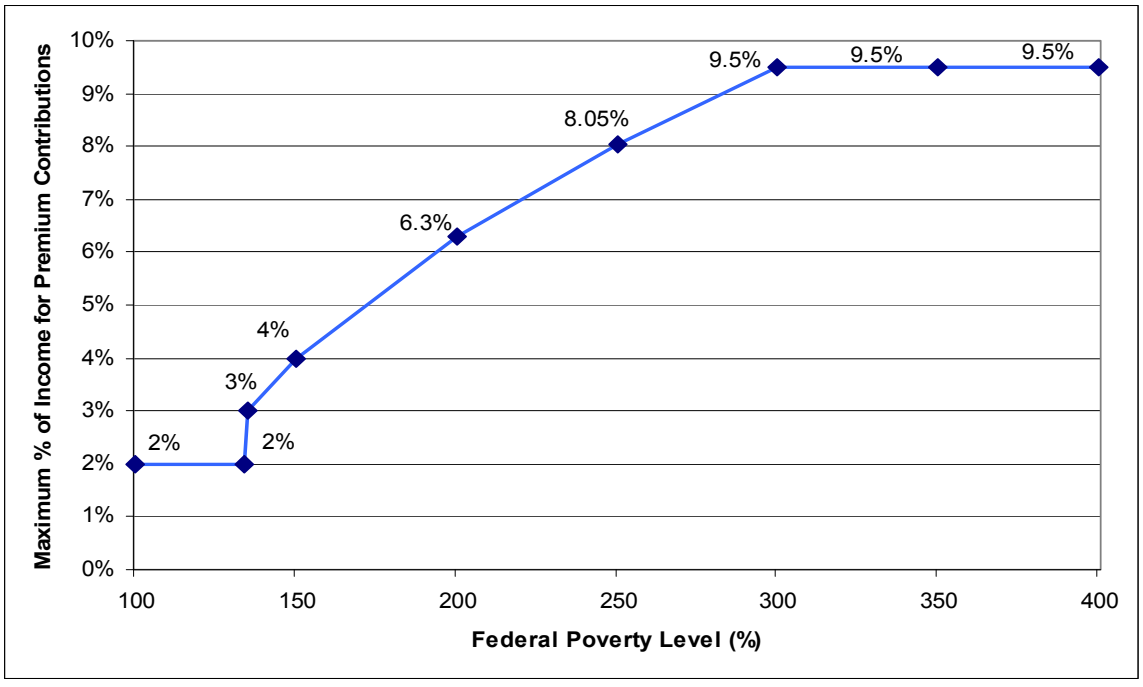
Choice of Exchange Plan Enrollment

While the calculation in Scenario B is based on the second-lowest cost silver plan in the taxfiler's local area, the qualifying individual/family may enroll in any tiered plan in an exchange and still be eligible for a tax credit. However, if the individual/family enrolls in a plan with a premium that exceeds the premium for the reference plan, the individiual/family is responsible for paying that additional amount.

Under Scenario B, the amount that a taxfiler who receives a premium credit is required to contribute toward the premium (for the reference plan) is capped as a percent of household income; that is, the *maximum premium contribution* is the product of the taxfiler's household income and the "applicable percentage," as specified in ACA. In general, the applicable percentage is less for those with lower incomes compared with those with higher incomes; where income is measured relative to the federal poverty level. Under Scenario B, the amount that taxfilers with income between 100% FPL and 133% FPL may be required to contribute toward the reference plan's premium is capped at 2% of household income. For taxfilers with income 300%-400% FPL, their premium contribution is capped at 9.5% of income. ACA further specifies the applicable percentages that taxfilers, whose incomes are between those two income bands, may be required to pay toward the cost of exchange coverage under Scenario B (see **Figure 1**).

Figure 1. Maximum Percentage of Household Income to Use Toward Premiums for the Second-Lowest Cost Silver Plan, by Percent of the Federal Poverty Level

Applicable to Premium Tax Credit Recipients



Source: CRS analysis of ACA.

The line graph shows the "applicable percentage" used to calculate the taxfiler's required premium contribution at each income level, as measured relative to the federal poverty level. The ACA statute specifies the applicable percentage at certain incomes (income at 100% FPL, 133% FPL, 150% FPL, etc.). At each of those incomes, the line changes slope. Specifically, at and

above 133% FPL up to 300% FPL, the applicable percentage increases *incrementally* as income increases. For example, a person with income at 150% FPL may be required to pay a maximum of 4% of household income toward exchange coverage. A 1% increase in income (i.e., person has income at 151% FPL) results in a maximum premium contribution equal to 4.05% of income.

Calculation of the premium credit amount (under Scenario B) is the arithmetic difference after subtracting the taxfiler's required premium contribution from the premium for the second-lowest cost silver plan ("reference plan") available to the taxfiler. It is theoretically possible that a person's required premium contribution could be equal to or exceed the reference plan's premium, leaving that taxfiler with a premium credit of zero.[37] Moreover, while the credit amount under this scenario is based on the reference plan, the individual/family may enroll in any metal-tier plan and still be eligible for credits. However, when a premium credit recipient enrolls in a plan that is more expensive than the reference plan, that person must pay the additional amount.

Premium Credits in 2014

Premium tax credits to be used toward paying for health insurance in the exchanges became available in 2014. **Table 2** displays selected annual income levels used in the calculation of premium credit amounts and required premium contributions, as discussed above.

Table 2. Selected Annual Income Levels Applicable to 2014 Premium Credits

Based on 2013 HHS Poverty Guidelines for the 48 contiguous states and the District of Columbia

Percent of Federal Poverty Line (FPL)	Family Size			
	1 person	2 persons	3 persons	4 persons
100%	$11,490	$15,510	$19,530	$23,550
133%	$15,282	$20,628	$25,975	$31,322
150%	$17,235	$23,265	$29,295	$35,325
200%	$22,980	$31,020	$39,060	$47,100
250%	$28,725	$38,775	$48,825	$58,875
300%	$34,470	$46,530	$58,590	$70,650
350%	$40,215	$54,285	$68,355	$82,425
400%	$45,960	$62,040	$78,120	$94,200

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

Notes: For 2014, the income levels used to calculate premium credit eligibility and amounts are based on 2013 HHS poverty guidelines. Different income levels, as measured against the FPL, apply separately to Alaska and Hawaii (see **Table 1**).

Table 3 displays the maximum *monthly* premium contributions for individuals and families who receive premium tax credits, provided that they enroll in the applicable reference plan.

[37] For an illustrative example, see hypothetical person "C" and table note "c" in **Table 4** of this report.

Table 3. Maximum Monthly Premium Contributions for Tax Credit Recipients Enrolled in the Second-Lowest Cost Silver Plan, 2014

Based on 2013 HHS Poverty Guidelines for the 48 contiguous states and the District of Columbia

Federal Poverty Line (FPL)	Maximum Premium Contribution based on a Percent of Income ("Applicable Percentages")	Maximum Monthly Premium Contributions for Tax Credit Recipients, by Family Size			
		1 person	2 persons	3 persons	4 persons
100%	2.0%	$20	$27	$34	$40
132.9%	2.0%	$26	$35	$44	$53
133%	3.0%	$39	$53	$66	$79
150%	4.0%	$58	$79	$99	$119
200%	6.3%	$122	$164	$206	$248
250%	8.05%	$194	$261	$329	$396
300%	9.5%	$274	$369	$465	$560
350%	9.5%	$319	$431	$542	$654
400%	9.5%	$365	$492	$619	$747

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

Notes: For 2014, the income levels used to calculate premium credit eligibility and amounts are based on 2013 HHS poverty guidelines. If individuals enroll in more expensive plans than the second-lowest cost silver plan in their respective areas, they would be responsible for the additional premium amounts. If the required premium contribution exceeds the actual premium amount, individuals would pay the entire premium for exchange coverage. The premium amounts have been rounded up to the nearest dollar amount.

Both **Figure 1** and **Table 3** illustrate the "cliff effect" that occurs at 133% FPL. For those individuals with income below 133% FPL, the credits ensure that such individuals pay no more than 2% of their income for the second-lowest cost silver plan. For incomes at or above 133% FPL, individuals and families may pay up to 3% of their income toward premiums for their reference plan. For example, an individual with income at 132.9% FPL (annual income of $15,270) may be required to pay $26 in monthly premiums for the second-lowest cost plan in 2014 (see **Table 3**). With 12 additional dollars of income (annual income of $15,282, equivalent to 133% FPL), this person may be required to pay $39 in monthly premiums. Therefore, the additional $12 in annual income could lead to an additional $156 in premium contributions for this hypothetical person in 2014. Nevertheless, some might observe that prior to implementation of the ACA premium credits in 2014, there were no federal subsidies for health coverage for individuals with income at this level and above, except for some narrowly defined groups. Thus, more individuals overall may be eligible for subsidized private coverage under the ACA, than before enactment of the law.

Premium Credit Examples: Self-Only and Family Coverage

The following hypothetical examples use actual exchange information about premiums, enrollee contributions, and premium credit amounts; the information was compiled using the plan finder tool at healthcare.gov.[38] To facilitate comparisons across hypothetical individuals and families,

[38] See https://www.healthcare.gov/find-premium-estimates/.

the premium and tax credit amounts apply to the same geographic location: Autauga County in Alabama (the first state and first county in the drop down menus in the plan finder tool). The examples in **Table 4** assume that the hypothetical individual (or family) is enrolled in the reference plan (second-lowest cost silver plan). As the 2014 premium data indicate, individuals at the same income level will face different (pre-credit) premiums based on age. This reflects the limited age rating allowed for health insurance policies, including those offered in the individual exchanges.[39] The practical effect of ACA's age rating requirements means that, for any given metal-tier plan in a specific geographic area, premiums vary for adults between 21 and 64+ years of age by a 3:1 ratio. (For examples that illustrate this 3:1 ratio, see hypothetical persons A, B, C, and D in **Table 4**, and the following analysis included under "Discussion of Self-Only Coverage Examples.") Moreover, the premium credit amounts are greater for those with lower incomes, compared with higher-income individuals of the *same age*, reflecting the income-based structure of the premium credits.

Table 4. Premium Contributions and Credit Amounts for the Second-Lowest Cost Silver Plans in 2014, by Selected Coverage Tiers

Applicable to Autauga County, Alabama

Coverage Tier	Hypothetical Person or Family – Letter Designation	Annual Income	Federal Poverty Level (FPL)	Maximum Premium Contribution as a % of Income	Age of Adult(s)[a]	Monthly (Pre-Credit) Premium for the Second-Lowest Cost Silver Plan[b]	Monthly Premium Contribution from Enrollee(s)	Monthly Credit Amount
Self-Only	A	$17,235	150%	4.0%	21	$201	$58	$143
	B	$17,235	150%	4.0%	64	$603	$58	$545
	C	$40,215	350%	9.5%	21	$201	$201[c]	$0
	D	$40,215	350%	9.5%	64	$603	$319	$284
Family of Three[d]	E	$29,295	150%	4.0%	40	$642	$99	$543
	F	$29,295	150%	4.0%	60	$1,219	$99	$1,120
	G	$68,355	350%	9.5%	40	$642	$542	$100
	H	$68,355	350%	9.5%	60	$1,219	$542	$677

Source: Income levels and poverty levels from "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf. Health plan premiums and credit amounts were compiled using the health plan finder tool at https://www.healthcare.gov/find-premium-estimates/.

Notes: For 2014, the income levels used to calculate premium credit eligibility and amounts in this table are based on 2013 HHS poverty guidelines for the 48 contiguous states and the District of Columbia.

a. Premiums for exchange plans are age-adjusted to allow for a maximum 3:1 variation for adults between 21 and 64+ years of age. For additional information about this and other rating restrictions, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

b. The premiums for the plans that are currently being offered through exchanges vary according to metal tier, geographic location, family size, age, and other factors.

c. The maximum premium contribution for an individual whose income is $40,215 in 2014 is $319 per month. However, the monthly premium is $201 in this example, which is a lower amount than the maximum

[39] See the "Rating Restrictions" discussion in CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

premium contribution. Given this, hypothetical person C pays the entire premium for coverage in the second-lowest cost silver plan, and the credit amount is zero.

d. Premiums for exchange plans are allowed to vary based on family size. In this table, hypothetical families E through H are each composed of two adults of the same age and one child who is age 19. Insurance rates for children are calculated by considering individuals under age 21 as one group. For example, if one child who is age 5 and another child who is age 19 enrolled in the same metal-tier plan, their premiums would be the same amount.

Discussion of Self-Only Coverage Examples

As indicated in **Table 4**, the monthly (pre-credit) premiums for self-only coverage in the second-lowest cost silver plan in Autauga County, AL, are $201 for a 21-year-old individual and $603 for a 64-year-old individual.[40] Given the 3:1 age-rating among adults between 21 and 64+ years of age, it follows that the premium for the same plan in the same county is three times higher for the older adults (hypothetical persons B and D), than it is for the younger adults (hypothetical persons A and C). However, for premium credit recipients, age does not determine the amount that a given person contributes toward her premium. The formula for calculating premium contributions from enrollees is based on income, not age (see **Table 3**), and such contributions are calculated prior to determining the credit amount. Therefore, the actual amount that tax credit recipients will pay toward exchange premiums may be the same for individuals with the same income levels, regardless of age. For example, persons A and B are very different in age but have the same income level; therefore, their monthly contributions toward premiums are the same amount ($58). Person C is an example of the exception to this general rule. Persons C and D have the same income level, so you would expect their premium contributions to be the same amount ($319, see **Table 3**). However, person C's premium ($201) is lower than the maximum premium contribution allowed for an enrollee at that income level. Therefore, person C pays the entire premium amount for the second-lowest cost silver plan available in that county.[41]

Discussion of Family Coverage Examples

The rules applicable to self-only coverage regarding age-rating for adults and calculation of enrollee premium contributions based on income likewise apply to family coverage. **Table 4** includes examples for hypothetical families comprised of two adults of the same age and one child who is age 19. Similar to the self-only coverage examples, the families with the older adults (families F and H) face a larger (pre-credit) premium than the families with the younger adults (families E and G). However, the families with the same income pay the same amount toward premiums. That is, families E and F pay $99 toward the monthly premium, while families G and H pay $542, for the same exchange plan.

Reconciliation of Premium Credits

Under ACA, the amount received in premium credits is based on the prior year's income tax returns. These amounts are reconciled when individuals file tax returns for the actual year in

[40] As discussed in the text box "Calculation of Premium Credit Amount" in this report, the actual credit amount will either be the premium of the exchange plan in which the taxfiler is actually enrolled (Scenario "A"), or the amount derived from the formula based on the second-lowest cost silver plan (Scenario "B"). Given this requirement, the examples included in this report assume that the hypothetical individuals/families enroll in the reference plan, even though credit recipients are allowed to enroll in any metal tier plan.

[41] Note that for person C the premium contribution equals approximately 6% of income; while person D's premium contribution equals the maximum 9.5% of income.

which they receive premium credits. If a tax filing unit's income decreases during the tax year, and the filer should have received a larger tax credit, this additional credit amount will be included in the tax refund for the year. On the other hand, any excess amount that was overpaid in premium credits will have to be repaid to the federal government as a tax payment. However, ACA imposes limits on the excess amounts to be repaid under certain conditions. For households with incomes below 400% FPL, the law includes specific limits that apply to single and joint filers separately—limits that will be indexed by inflation in future years.

Since the enactment of ACA, these limits have been amended twice: first under the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), and then under the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayment Act of 2011 (P.L. 112-9). The current repayment limits vary by income band (see **Table 5**). For example, say a family received overpayments for the tax credits they should have received in a given tax year. They will have to repay the excess when they file federal income taxes for that year. However, if such a family has income below 200% FPL, the IRS may only require them to repay up to $600 (for tax credit overpayments during that tax year). In other words, while such a family may technically owe a larger amount, repayment is limited to a maximum of $600 for a family with income below 200% FPL.

Table 5. Limits on Repayment of Excess Premium Credits Enacted by the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayment Act of 2011 (P.L. 112-9)

If Household Income (Expressed as a Percentage of the Federal Poverty Level) Is:	The Applicable Dollar Limit for Joint Filers Is:
Less than 200%	$600
At least 200% but less than 300%	$1,500
At least 300% but less than 400%	$2,500

Note: The applicable dollar limit for single filers is 50% of the joint filer limit.

Enrollment: Exchanges and Premium Credits

As of March 1, 2014, the cumulative total for *individual* exchange enrollment was approximately 4.2 million persons.[42] *At least* 3.5 million of these individuals qualified for premium tax credits.[43]

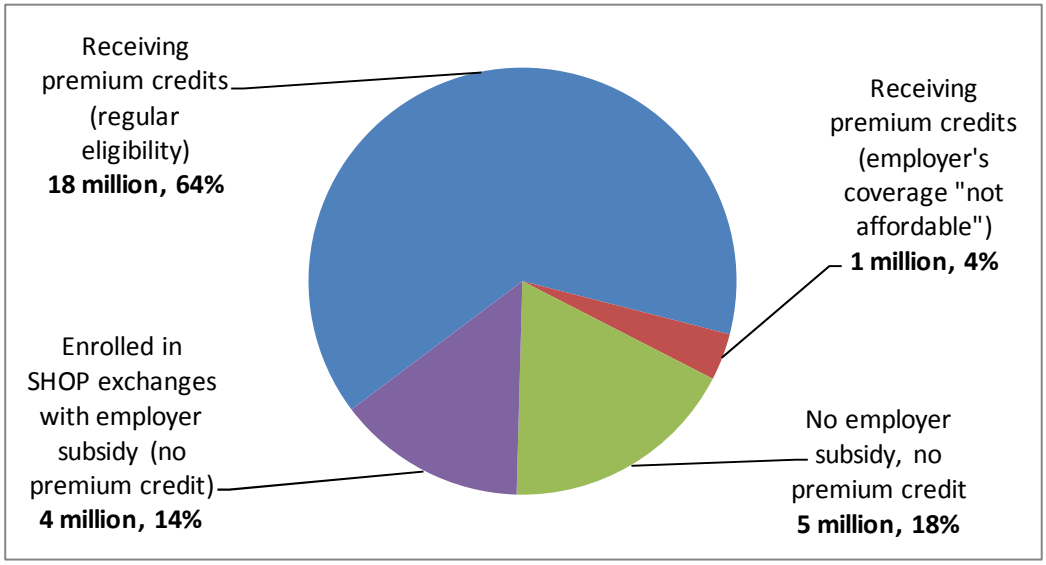
In its estimates for ACA's health coverage provisions, the Congressional Budget Office (CBO) projects exchange enrollment to be modest in the first couple years, then increase significantly afterwards. Likewise, the estimates of federal outlays for premium credits are relatively moderate initially, but increase rapidly after the first few years. According to its latest estimates, CBO projects exchange enrollment in 2014 to total 8 million persons: 6 million and 2 million enrolled in individual and SHOP exchanges, respectively. By 2024, CBO estimates that 28 million individuals total will be enrolled in exchange coverage. Of those exchange enrollees who are enrolled in the individual exchanges (24 million), 19 million are projected to receive premium

[42] See Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplace: March Enrollment Report," March 11, 2014, http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf.

[43] Financial data are available for all but 83,687 persons enrolled in individual exchanges. Therefore, it is possible that more than 3.5 million exchange enrollees qualified for tax credits as of March 1, 2014.

credits (see **Figure 2**). CBO estimates that premium credits will increase federal outlays by $899 billion, from FY2015 through FY2024.[44]

Figure 2. Total Estimated Exchange Enrollment, 2024



Source: U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act , February 4, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf.

Notes: Beginning in 2014, an employer's coverage is not "affordable" when the employee's contribution toward the premium for the employer's lowest-cost, self-only plan would exceed 9.5% of household income. Employees with an employer offer of coverage may also be eligible for premium credits if the employer plan does not provide minimum value (i.e., covers less than 60% of total allowed costs). However, the CBO projection of individuals eligible for premium credits (besides meeting other eligibility criteria) because the employer plan would not provide minimum value was well under 1 million, and therefore not included in CBO published estimates or in this figure.

Cost-Sharing Subsidies

In addition to the premium credits, ACA establishes subsidies that are applicable to cost-sharing expenses. An individual who qualifies for the premium credit *and* is enrolled in a silver plan (actuarial value of 70%) through an exchange is also eligible for cost-sharing assistance.[45] The assistance is provided in two forms, and both forms are based on income (see descriptions below). Individuals who receive cost-sharing subsidies may receive both types, as long as they meet the applicable eligibility requirements.

ACA requires each metal tier plan to limit the total amount an enrollee will be required to pay out of pocket for use of covered services in a year (referred to as an annual cost-sharing limit in this report), and establishes separate limits for self-only coverage and family coverage. For 2014, the

[44] U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act , February 4, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf.

[45] ACA establishes different eligibility criteria for cost-sharing subsidies for certain American Indians and Alaska Natives. For more information, see CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*.

annual cost-sharing limit for self-only coverage is $6,350; the corresponding limit for family coverage is $12,700.[46] Given that tiered plans will already be required to comply with those annual cost-sharing limits, one form of cost-sharing assistance reduces such limits (see **Table 6**). The cost-sharing assistance reduces the annual limit faced by eligible individuals with income between 100% and 250% FPL; greater reductions are provided to those with lower incomes. In general, this cost-sharing assistance targets individuals and families who use a great deal of health care in a year and, therefore, have high cost-sharing expenses. Enrollees who use very little health care do not generate enough cost-sharing expenses to reach the annual limit.

Table 6. ACA Cost-Sharing Subsidies: Annual Cost-Sharing Limits, by Household Income Tier

Household Income Tier, by Federal Poverty Level	New Annual Cost-Sharing Limits for 2014	
	Self-Only Coverage	Family Coverage
100% - 150%	$2,250	$4,500
Greater than 150% - 200%	$2,250	$4,500
Greater than 200% - 250%	$5,200	$10,400

Source: "HHS Notice of Benefit and Payment Parameters for 2014," 78 *Federal Register* 15483, March 11, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

Note: The cost-sharing limits applicable to tiered plans established under ACA uses existing limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2014, the cost-sharing limits for HSA-qualified HDHPs are $6,350 for self-only coverage, and $12,700 for family coverage. The cost-sharing subsidy reduces these limits based on income.

The second form of cost-sharing assistance also applies to individuals with income between 100% and 250% FPL. For eligible individuals, the cost-sharing requirements (in the plans they have enrolled) have been reduced to ensure that the plan covers a certain percentage of allowed health care expenses, on average. The practical effect of this cost-sharing assistance is to increase the actuarial value (AV)[47] of the exchange plan in which the person is enrolled (see **Table 7**), so enrollees face lower cost-sharing requirements than they would have without this assistance. Given that this form of cost-sharing assistance directly affects cost-sharing requirements (e.g., lower deductible), both enrollees who use minimal health care and those who use a great deal of services may potentially benefit from this assistance.

[46] The cost-sharing limits established under this ACA provision uses existing limits applicable to high-deductible health plans (HDHPs) that may be paired with health savings accounts (HSAs). Therefore, the annual cost-sharing limits that apply to a given metal tier plan is based on the cost-sharing limits applicable to HSA-qualified HDHPs; see "Revenue Procedure 2013-25," http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.

[47] Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. In other words, the higher the percentage, the lower the cost-sharing, on average. AV is not a measure of premiums or the benefits package. Two plans with the same AV may have different premiums and different sets of covered benefits.

Table 7. ACA Cost-Sharing Subsidies: Actuarial Values, by Household Income Tier

Household Income Tier, by Federal Poverty Level	New Actuarial Values for Cost-Sharing Subsidy Recipients
100% - 150%	94%
Greater than 150% - 200%	87%
Greater than 200% - 250%	73%

Source: "HHS Notice of Benefit and Payment Parameters for 2014," 78 *Federal Register* 15484, March 11, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

In order to be eligible for cost-sharing subsidies, an individual must be enrolled in a silver plan, so that coverage already has an AV of 70%. For an individual who receives the subsidy referred to in **Table 7**, the health plan imposes a set of different cost-sharing requirements, so the "silver" plan will meet the new applicable AV. ACA does not specify how a plan reduces cost-sharing requirements in order to increase the AV from 70% to one of the higher AVs. Through regulations, HHS requires each insurance company that offers a plan that is subject to these cost-sharing reductions to develop variations of its silver plan; these plan variations must comply with the higher levels of actuarial value (73%, 87%, and 94%).[48] When an individual is determined by an exchange to be eligible for a cost-sharing subsidy, the person is enrolled in the plan variation that corresponds with that person's income (as indicated in **Table 7**). This approach ensures that the individual automatically benefits from this cost-sharing assistance, as soon as exchange coverage becomes effective.

The HHS Secretary will provide full reimbursements to exchange plans that provide cost-sharing subsidies.[49] CBO estimates that the cost-sharing subsidies will increase federal outlays, from FY2015 through FY2024, by $167 billion.[50]

Author Contact Information

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

[48] See "HHS Notice of Benefit and Payment Parameters for 2014," 78 *Federal Register* 15484, March 11, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

[49] A given health plan is required to submit, to HHS, estimates of the amount of cost-sharing assistance it will provide in a year. Such estimates must be submitted prior to that year, in order to receive advance payments for the estimated amount of cost-sharing assistance. A plan must also submit to HHS actual amounts of cost-sharing assistance provided. The actual amounts will be periodically reconciled with the amounts received by the plan in advance payments. For additional information about these submission and payment processes, see 45 C.F.R. §156.430.

[50] U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act , February 4, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf.